



**Accessible Physical Therapy Services, LLC**

**PATIENT INFORMATION FORM**

Today's date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cellular Phone: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: F\_\_ M\_\_ Marital Status: \_\_\_\_\_

Employer Name & Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

Will you be using your health insurance?  Yes  No I DO NOT HAVE HEALTH INSURANCE: \_\_\_\_\_ (initial)

**Primary Insurance Carrier & Address:** \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_ Phone number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Secondary Insurance Carrier & Address:** \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_ Phone number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Is this related to an accident? If yes complete the following:**  Yes  No

**AUTOMOBILE ACCIDENT/ WORKERS COMPENSATION INSURANCE INFORMATION**

Date of Accident: \_\_\_\_\_ Cause of Injury:  Auto  Work Comp  Other State Injury Occurred: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Med Pay Benefit Available: \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Name of Adjuster: \_\_\_\_\_ Adjuster's Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Third Party Auto Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Attorney Name & Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Case Manager: \_\_\_\_\_

Please remember that Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as "Reasonable and customary fees." We do not accept this as payment in Full (unless otherwise restricted by law or agreement we may have with your insurer). Also, some of the insurance companies only pay a percentage of the charge. **IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT.** In the event the account is turned over for collections, the collections fees and/or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to the facility listed in the top

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment via fax transmittal or hard copy.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_